Approved Exception To SF 171
OMB No. 2900-0205
Estimated burden: 30 minutes

Department of Veterans Affairs

APPLICATION FOR ASSOCIATED HEALTH OCCUPATIONS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER.

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. OCCUPATION FOR WHICH APPLYING

A ☐ CERTIFIED RESPIRATORY THERAPY TECHNICIAN
B ☐ REGISTERED RESPIRATORY THERAPIST
C ☐ LICENSED PHYSICAL THERAPIST
D ☐ LICENSED PRACTICAL/VOCATIONAL NURSE
E ☐ LICENSED PHARMACIST
F ☐ PHYSICIAN ASSISTANT
G ☐ EXPANDED-FUNCTION DENTAL AUXILIARY
H ☐ OCCUPATIONAL THERAPIST
I ☐ OTHER (Specify)

2. NAME (Last, First, Middle)	3. APPLICATION FOR (Check one) ☐ GENERAL PRACTICE ☐ SPECIALTY (Identify below)
4. PRESENT ADDRESS (Include ZIP Code)	5. TELEPHONE NUMBER (Include Area Code) 5A. RESIDENCE / 5B. BUSINESS
6. DATE OF BIRTH	7. PLACE OF BIRTH / 8. SOCIAL SECURITY NUMBER
9A. CITIZENSHIP ☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 9B)	9B. COUNTRY OF WHICH YOU ARE A CITIZEN
10A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA ☐ YES ☐ NO (If "YES" complete items 10B and 10C)	10B. NAME OF OFFICE WHERE FILED / 10C. DATE FILED
11. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER	12. DATE AVAILABLE FOR EMPLOYMENT

I – ACTIVE MILITARY DUTY

13A. DATE FROM	13B. DATE TO	13C. SERIAL OR SERVICE NO.	13D. BRANCH OF SERVICE	13E. TYPE OF DISCHARGE ☐ HONORABLE ☐ OTHER (Explain on separate sheet)

II – LICENSURE, DEA CERTIFICATION, REGISTRATION AND CLINICAL PRIVILEGES (As applicable)

14A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED (If not held now, explain on separate sheet)	14B. LICENSE NO.	14C. CURRENT REGISTRATION (If "NO" explain on separate sheet) YES	NO	NOT REQUIRED	14D. EXPIRATION DATE

15A. ARE YOU FULLY LICENSED IN EVERY STATE IN WHICH YOU RECEIVED A LICENSE (If restricted, limited or probational in any State(s), explain on separate sheet) ☐ YES ☐ NO ☐ NOT APPLICABLE	15B. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD A STATE LICENSE TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED ☐ YES ☐ NO (If 'YES' explain on separate sheet)	15C. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT ☐ YES ☐ NO (If "YES" explain on separate sheet)

16A. NAME THE CERTIFYING BODY FOR YOUR HEALTH OCCUPATION	16B. DATE OF MOST RECENT REGISTRATION/ CERTIFICATION (Give Month and Year)	16C. WHAT IS YOUR REGISTRY/ CERTIFICATION NUMBER	16D. HAS ACTION EVER BEEN TAKEN AGAINST YOUR CERTIFICATION OR REGISTRATION ☐ YES ☐ NO (If "YES" explain on separate sheet)

17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION ☐ YES ☐ NO (If "YES" complete item 17B)	17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD	17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, OR VOLUNTARILY RELINQUISHED ☐ YES ☐ NO (If "YES" explain on separate sheet)

III – THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

CERTIFICATION: I certify that I have verified licensure and registration with State boards, and sighted visa or citizenship. Board certification has been verified (if appropriate).

18. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:

☐ CERTIFICATION OR REGISTRATION
☐ NATURALIZED CITIZENSHIP
☐ LICENSURE/REGISTRATION FOR ALL STATES LISTED BY APPLICANT
☐ VISA
☐ CURRENT OR MOST RECENT CLINICAL PRIVILEGES
☐ NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES

19A. SIGNATURE OF AUTHORIZED OFFICIAL	19B. TITLE	19C. DATE (MONTH, DAY, YEAR)